2005 WL 4844157 (Mich.Cir.Ct.) (Trial Motion, Memorandum and Affidavit)
Circuit Court of Michigan.
Wayne County

Carol Ann KUSHLER, Personal Representative of the Estate of James Richard Stykos, Deceased, Plaintiff,

v.

STALLWORTH AFC #1 CORPORATION, a Michigan corporation d/b/a Stallworth AFC, Community Case Management Services, Inc., a Michigan corporation, jointly and severally, Defendants.

No. 04-416086-NO.
May 26, 2004.
June 30, 2005.

Plaintiff's Response to Defendant's Motion for Summary Disposition

Jon R. Garrett (P25777), Attorney for Plaintiff, Garrett & Stevenson, P.C., 535 Griswold St., Suite 1650, Detroit, Michigan 48226, (313) 961-1885.

Joseph F. Babiarz, Jr. (P38711), Attorneys for Defendants, Plunkett & Cooney, P.C., 38505 Woodward Ave., Ste. 2000, Bloomfield Hills, Michigan 48304, (248) 594-6305.

JDG: William J Giovan.

I. *INTRODUCTION*:

In the late hours of May 5, 2003, or the early morning hours of May 6, 2003, James, who was 49 years old, was beaten to death. His body was discovered between 7:00 a.m. and 8:00 a.m. on May 6 by the police in a high school field near the Defendant's AFC home. According to Defendant's employees, he was last seen by anyone at Defendant's AFC home at approximately 8:00 p.m. of May 5th. He was seen walking out the door by Ms. Samuels, who was one of Defendant's employees. She neither asked James where he was going nor when he would return. (Exhibit 1, Samuels deposition, p 5.) According to Ms. Stallworth, the owner and manager of this AFC home, this is in violation of the home's policies, which require the employees to be aware of this information. (Exhibit 2, Deposition of Gail Stallworth, p 42.) Further, as will be presented herein, not knowing where a resident is, is a violation of MCL 400.707(7)(d). As to whether James left the facility at 8:15 p.m. or not, there are assertions by his roommate, Mr. Richard Donaldson, that he in fact left at 6:00 p.m. on May 5. (See Exhibit 3 hereto.)

The AFC home has internal House Policies which are read and signed by each resident upon admittance, including James. These policies MUST be complied with. Right above James' signature, in all caps, it reads as follows:

“MY SIGNATURE BELOW IS TO ACKNOWLEDGE THAT I HAVE READ THE STALLWORTH AFC HOUSE RULES. IT IS MY UNDERSTANDING THAT ANY VIOLATION OF THESE POLICIES AND/OR DSS LICENSING REGULATIONS CAN RESULT IN IMMEDIATE TERMINATION OF MY RESIDENCY.”

(See Exhibit 4 hereto.)

Of significance in these rules to the case herein is Rule 10, which reads as follows:

"ALL RESIDENTS MUST BE IN BY 11:00 PM, UNLESS THE RESIDENT IS VISITING WITH RELATIVES OR FRIENDS. THE ALARMS ARE SET PROMPTLY AT 11:00. NO RESIDENT IS PERMITTED TO RETURN OR LEAVE THE FACILITY AFTER 11:00 PM. THE ALARMS ARE REMOVED AT 6:30AM. RESIDENTS MAY RETURN AT THAT TIME."

(See Exhibit 4 hereto.)

The Defendant asserts that this Rule is not real. That they always let individuals back in, even if they returned after 11:00 p.m. They assert that James knew this. Their assertions are disingenuous and self-serving, at best.

James did not return by 11:00 p.m., and Ms. Samuels testified that she was concerned. (Exhibit 1, p 9.) Ms. Cawthorn, who was also working that shift, was also concerned as this was the first time James was late. The house policy is that if a resident does not return the staff is to call Ms. Stallworth and she will direct them as to what to do. (Exhibit 1, pp 7-8.) With James missing at 11:00 p.m., and with the doors locked and the alarms on, Ms. Cawthorn called Ms. Stallworth and so advised. (Exhibit 6, Deposition of Samuels, p 8.) She was told to do nothing by Ms. Stallworth. The Defendant asserts that the police will not respond until 24 hours elapse. This is contrary to the testimony of Mr. Price, who was also a worker for Defendant, who testified that on other occasions they contact the police right away. (Exhibit 7, Deposition of Price, pp 12-13.)

No one went to look for James, although Mr. Price testified that James would usually wander to just three or four places nearby the home (i.e. a gas station, grocery store and the like). (Exhibit 7, p 11.) In the morning, James' death was on the news and most, if not all, of the staff knew of it early that morning. Still nothing was done. Not until 4:15 p.m. on the 6th of May did Ms. Stallworth direct Ms. Samuels to file a missing person report with the police. (Exhibit 1, pp 22-23.) This was after they knew James was dead!

JAMES' CONDITION UPON ARRIVAL AND DURING HIS STAY AT THE STALLWORTH AFC HOME:

When James was 15 years of age, he was diagnosed as suffering from mental illness for the first time. He has had a long list of mental illness diagnoses over the many years. Most recently, though, his diagnosis was paranoid schizophrenia, poly drug abuse and seizure disorder. James had many in-patient psychiatric hospitalizations over the years; sometimes in for a few days and out in one placement or another for long periods of time, usually residing with his mother. His final hospitalization was at Walter Reuther Psychiatric Hospital from January of 2000 through January 25, 2002, when he was transferred into the Defendant's Adult Foster Care facility.

James had lived in the Defendant AFC home for approximately 16 months. To understand his condition, needs, requirements for mental health services and what the Defendant knew of James' condition, can be evidenced by examining the Individual Support Plan of Service (hereinafter "IPS"), which Defendant agreed contractually to fulfill. (See Exhibit 8 hereto.) The IPS (Exhibit 9), according to Defendant in its brief to this Court, suggests that it provides for James to freely walk around in the community. This is simply untrue. There is not one word to suggest such a thing within the IPS. To the contrary, the IPS contains the following identification of problems and it states:
"PROBLEM #1: Mr. Stykos is *unable to live and care for his personal needs independently in the community*. He has history of psychiatric hospitalizations due to hostile behavior...

"PROBLEM #2: Consumer has difficulty living in environment independently caring for personal needs Client will comply with AFC home rules." (Emphasis added.)

Further, the Case Management Comprehensive Assessment (Exhibit 10 hereto), created shortly after James arrived at Defendant AFC home and which the Defendant had on file, is significant. He was given a level of care designated as "Specialized IIA," which is a high level of care required. Ms. Lane, an employee of Defendant, testified that that level of care required "special attention." (Exhibit 11, Deposition of Lane, p 22.) Mr. Price, an employee of Defendant, also testified "that means he should be watched and accompanied by a staff person at all times. I mean they just let him be free to go as he wanted to. The first day that he came into our program, he walked off. I had to go find him." (Exhibit 7, p 7.) James' diagnosis was that of paranoid schizophrenic, poly substance abuse and seizure disorder. Of significance under the section entitled, "SAFETY AND MOBILITY IN HOME/ NEIGHBORHOOD," it is noted:

> "CLIENT STATED HE FEELS SAFE AT AFC HOME, HAS BEEN GOING FOR WALKS-ALWAYS WITH PEERS."

Part of James' treatment plan included treatment from New Center Community Mental Health Services. Their records reveal the nature of James' condition during his stay at Defendant's AFC home up till nearly his death. These records, among other things, reveal:

• On 5-10-02, at a New Center meeting which Ms. Jackson, the Defendant's Assistant Home Manager, attended, it was noted that the reason for Plaintiff's transfer from Walter Reuther Hospital to the Defendant AFC home was because;

"CLIENT HAS DEMONSTRATED A NEED FOR MORE INTENSIVE SERVICES *DUE TO RECENT WANDERING AWAY FROM HOME*, DELUSIONAL THINKING AND HYPER BEHAVIOR."

(See Exhibit 12 hereto, emphasis added.)

Further, on said date it was noted:

> "CLIENT HAS BEGUN TO SHOW SIGNS OF DECOMPENSATION SUCH AS INCREASE PARANOIA AND BIZARE BEHAVIOR AND WANDERING AWAY FROM AFC HOME. CLIENT NEEDS MORE INTENSIVE SERVICES."

(See Exhibit 12 hereto.)

• On 11-14-02, in a physician meeting with Ms. Jackson, the assistant manager of Defendant, it was related that James was being discharged from the day program due to the need of intense staff involvement and it was noted that he likely would have great potential for regression. (See Exhibit 10 hereto.) The physician discharge notes the following. (See Exhibit 13.)

"Patient continued to be extremely disruptive in the AFC home and we had several meetings with Mrs. Jackson who justified his behavior as childish... Patient had to be administratively discharged because he continued to make threats to staff...Patient continued to show grave disabling and incapacitating symptoms and might require long term state hospital for chronic patients." (See Exhibit 14 hereto.)

• On 1-5-03, the New Center progress notes reveals:

"Marginally stable. Continues to need monitoring by AFC staff." (See Exhibit 15 hereto.)

On 2-3-03, Plaintiff received his last psychiatric update from the New Center before his death, and it states in pertinent part as follows:

"Client was brought in by AFC home manager...*CLIENT REQUESTED A BUS CARD APPLICATION, AFC HOME MANAGER STATED THAT CLIENT IS NOT ALLOWED OUT IN THE COMMUNITY UNSUPERVISED BECAUSE HE HAS A TENDENCY TO WANDER AND TRIES TO VISIT HIS MOTHER.*" (See Exhibit 16 hereto; emphasis added.)

Ethically, in light of this, how can Defendant assert that James could travel freely within the community and they couldn't stop him? The defendant's assertion to this Court is, in fact, a LIE.
• On 2-12-03 James received a psychiatric update from New Center, and it states in pertinent part as follows:

"Now he continues to live at Stallworth AFC home, still exhibits some delusional thinking and responding to auditory hallucinations. No threatening behavior. HE HAS A TENDENCY TO WANDER AROUND...IT IS FURTHER NOTED THAT HE HAS POOR ISNIGHT INTO HIS CONDITON AND NEEDS." (See Exhibit 17 hereto.)

• On 4-9-03 in his last visit to the New Center it was noted that James has "poor insight into his illness." (See Exhibit 18 hereto.)

• On 4-30-03, just five days before his death, it was noted in a visit by New Center to the Defendant AFC that James was in fact going to be relocated into a new AFC home. (See Exhibit 19 hereto.)

From the foregoing, it is quite apparent that James needed constant supervision and it was noted repeatedly from the moment of his transfer from Walter Reuther Hospital into the Defendant's AFC home that James had a problem with wandering away. Further, he was incapable of independently taking care of his basic needs. It must be noted that Defendant signed an agreement with the agency who placed James into the Defendant AFC home that the Defendant would:
• Comply with the AFC licensing act and its rules and regulations.

• Carry out the specific services and program identified in the IPS.

• Notify the agency at least one month in advance of any condition that exists which may require termination of a placement, unless an emergency situation arises.

• To refuse placement of a resident who is felt to be incompatible with the current resident population or one who the facility and staff do not have appropriate resources or skills to adequately manage and service. (See Exhibit 8 hereto.)

II. *STANDARD OF REVIEW*:

Looking first to a motion for summary disposition pursuant to MCR 2.116(C)(10), it is well established that such a motion should not be granted unless the trial court is satisfied that it is impossible for a claim to be supported at trial because of some deficiency that cannot be overcome. *Merillat v Michigan State University*, 207 Mich App 240 (1994); *Jozwiak v Northern Michigan Hospitals, Inc*, 207 Mich App 161 (1994); *Garvelink v The Detroit News*, 206 Mich App 604 (1994). Courts are liberal in finding that genuine issues of material fact exist in a case. *Stehlik v Johnson*, 204 Mich App 53 (1994); *Bowkus v Lange*, 196 Mich App 455 (1992); *Schippers v SPX Corp*, 194 Mich App 52 (1992). Accordingly, if the record might develop in such a way that will leave open an issue upon which reasonable minds could differ, the motion should be denied. *Wolfe v Employers Health Insurance Co*, 194 Mich App 172 (1992); *Tidwell v Dasher*, 152 Mich App 379 (1986).

The trial court must give the benefit of any reasonable doubt to the non-moving party and all legitimate inferences must be drawn in favor of the non-moving party. *Coleman-Nichols v Tixon Corp*, 203 Mich App 645 (1994); *Pernick v Brandt*, 201 Mich App 293 (1993); *Libralter Plastics, Inc v Chubb Group of Insurance Companies*, 199 Mich App 482 (1993). Additionally,

the trial court may not make factual findings or weigh the credibility of the evidence in deciding such a motion. *Barnell v Taubman Co, Inc*, 203 Mich App 645 (1993).

A motion for summary disposition brought under MCR 2.116(C)(8), for failure to state a claim upon which relief can be granted, is tested by the pleadings alone and examines only the legal basis of the complaint. *Maiden v Rozwood*, 461 Mich 109, 119, 597 NW2d 817 (1999); *Horace v City of Pontiac*, 456 Mich 744, 749, 575 NW2d 762, 764 (1998); *HJ Tucker & Assoc, Inc v Allied Chucker & Engineering Co*, 234 Mich App 550, 595 NW2d 176 (1999); *Blackwell v Citizens Ins. Co of America*, 457 Mich 662, 579 NW2d 889 (1998); *Brown v Michigan Bell Telephone, Inc*, 225 Mich App 617, 572 NW2d 33 (1997). The well-pleaded factual allegations in the complaint must be accepted as true, together with any inferences that can reasonably be drawn therefrom. *Maiden v Rozwood*, 461 Mich 109, 119, 597 NW2d 817 (1999); *Theisen v Knake*, 236 Mich App 249, 599 NW2d 777 (1999); *MacDonald v PKT, Inc*, 233 Mich App 395, 593 NW2d 176 (1999). Summary disposition is properly granted if the claim is so clearly unenforceable as a matter of law that no factual development could possibly justify recovery. *Maiden*, *supra* at 119; *Simko v Blake*, 448 Mich 648, 654, 532 NW2d 842 (1995). The mere statement of the pleader's conclusions, unsupported by allegations of fact, will not suffice to state a cause of action. *Butler v Ramco-Gershenson, Inc*, 214 Mich App 521, 542 NW2d 912 (1995); *Golec v Metal Exchange Corp*, 208 Mich App 380, 528 NW2d 756 (1995), affirmed, 453 Mich 149, 551 NW2d 132 (1996); *Ulrich v Federal Land Bank of St Paul*, 192 Mich App 194, 480 NW2d 910 (1991).

Summary disposition should be granted under MCR 2.116(C)(8) if the court determines that the defendant has no legal duty to the plaintiff. Whether a duty exists is a question of law for the court. *Harts v Farmers Ins Exchange*, 461 Mich 1, 6, 597 NW2d 47, 50 (1999).

III. *DUTY OF DEFENDANT*:

The Defendant suggests that it had no duty to aid or protect another, citing *Williams v Cunningham Drug Stores, Inc*, 429 Mich 495 (1988), which of course is a premises case, and this is not. Even when analyzing this under a *Williams* perspective, there is a limited exception and that is when there is a special relationship, as described in Murdock v Higgins, 445 Mich 46 (1997), and thus, if a special relationship exists, then the defendant owes to plaintiff a duty of reasonable care. (See *Dykema v Gus Macker Enterprises*, 196 Mich App 6 (1992).

The Defendant suggests that because Plaintiff was fully capable of leaving the home and had chosen to do so, the duty of reasonable care was severed. While Defendant may wish this to be true, it is not. The Defendant asserts that it has no duty to monitor Plaintiff while he is moving freely within the community. As will be seen, this assertion is baseless and contrary to statutory law.

Michigan Courts have succinctly delineated the concept of duty in the negligence context, drawing upon the Supreme Court's seminal opinion in *Moning v Alfono*, 400 Mich 425 (1977):

> "Duty is essentially a question whether the relationship between the actor and the injured person gives rise to any legal obligation on the actor's part for the benefit of the injured person. Where there exists no legal duty, no actionable negligence exists."

Lindsley v Burke, 189 Mich App 700, 703 (1991) (citations omitted).

While it is often the case that a legal duty arises by operation of common law, a legal duty may also be imposed by statute. *Riddle v McLouth Steel Products Corp*, 440 Mich 85, 95 (1992); *Clark v Dalman*, 379 Mich 251, 261 (1961); *Phillips v Deihm*, 213 Mich App 389, 397 (1995); *Mays v Gillett Communications of Detroit*, 198 Mich App 223, 225, *lv den*, 44 Mich 880 (1993). A duty of due care may even arise out of a contractual relationship. *Clark*, *supra*.

As a general rule, duty is a question of law for the court to decide. *Riddle*, *supra*; *Braun v York Properties, Inc*, 230 Mich App 138, 141 (1998). However, there are circumstances in which the trier of fact does have a role when there is a dispute over whether the proofs establish the elements of a relationship that the court has already concluded give rise to a duty as a matter of law:

> "It is for the court to determine, as a matter of law, what characteristics must be present for a relationship to give rise to a duty the breach of which may result in tort liability. It is for the jury to determine whether the facts in evidence establish the elements of that relationship."

Smith v Allendale Mutual Insurance Co, 410 Mich 685, 714 (1981).

Thus, it is for the jury to determine whether or not a special relationship existed herein. The Defendant should just admit same.

***STATUTORY DUTIES OWED TO PLAINTIFF BY DEFENDANT*:**

The Defendant has a duty to protect James from harm, including physical injuries, pursuant to the AFCFLA MCL 400.701 *et seq*. Further, Defendant has a duty to provide James with a safe and humane living environment pursuant to the Mental Health Code, MCL 300.1708. The specific duties are presented below:

A. *The Adult Foster Care Facilities Licensing Act, MCL 400,701* et seq.

The definition of "Foster Care" in the act is as follows:

> "Foster care" means the PROVISION OF SUPERVISION, PERSONAL CARE and PROTECTION in addition to room and board, for *24 HOURS A DAY*, 5 or more days a week, and for 2 or more consecutive weeks for compensation. MCL 400,704(6).

Of course, James had been residing at Defendant's Adult Foster Care home for far longer than two weeks.

The AFCFLA defines supervision as follows:
Supervision *means* guidance of a resident in the activities of daily living, including all of the following:

(d) *BEING AWARE OF A RESIDENT'S GENERAL WHEREABOUTS EVEN THOUGH THE RESIDENT MAY TRAVEL INDEPENDENTLY ABOUT THE COMMUNITIY*. MCL 400.707(7)(d).

The definition of "Protection" is defined in the Act as follows:

"*...MEANS THE CONTINUAL RESPONSIBILITY OF THE LICENSEE TO TAKE. REASONABLE ACTION TO INSURE THE HEALTH, SAFETY AND WELL-BEING OF A RESIDENT, INCLUDING PROTECTION FROM PHYSICAL HARM, humiliation, intimidation and social, moral, **financial** and personal **exploitation*** while on the premises, while under the supervision of the licensee, or an agent or employee of the licensee, or *when the residents assessment plan states that the resident needs continuous supervision*." (See MCL 400.706(6)(4)).

Pursuant to the AFCFLA, there have been Rules promulgated that are relevant herein and will be described below.
• R 400.15206(2) provides: "A licensee shall have sufficient direct care staff on duty at all times for the *SUPERVISION, PERSONAL CARE, AND PROTECTION* of residents and to provide the services specified in the resident's resident care agreement and assessment plan. (Emphasis added.)

• R 400.15303(2) provides: "A licensee shall provide SUPERVISION PROTECTION *AND PERSONAL CARE* as defined in the act and as specified in the resident's assessment plan. (See Exhibit 20 hereto.)

In this case it is undisputed that Stallworth is a licensed adult foster care home by the State of Michigan. Stallworth provides beds for CCMS pursuant to contract. It should, therefore be undisputed that Stallworth is a provider of mental health services. It is further undisputed that James Stykos was a recipient of mental health services. Accordingly, the relationship between Stallworth and Mr. Stykos is governed by Mental Health Code, MCL 330.1011, *et seq;* MSA 14.800(1), *et seq*.

B. *The Michigan Mental Health Code*

The Mental Health Code imposes a variety of duties and responsibilities upon providers of mental health care services, obligations that run to the benefit of recipients of such services, and are fashioned as "rights" of recipients by the Code itself. Pertinent to this case are the following:
• A recipient of mental health services is entitled to the provision of such services in a manner designed to "*protect and promote the dignity and respect to which a recipient of services is entitled*." MCL 330.1704.

• A recipient of mental health services shall be provided (such services) *in a safe, sanitary and humane environment*." MCL 330.1708(2).

• *A recipient of mental health services shall not he subjected to abuse or neglect*. MCL 330.1722(1).

Further, on the issue of whether or not the Defendant could restrict Plaintiffs leaving the facility for a walk in the neighborhood without accompaniment MCL 330.1744(1) states:
The freedom of movement of a recipient shall not be restricted more than necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage."

In light of MCL 400.706(6)(4), the duty issue presented herein, then, is whether or not the Defendant acted reasonably to ensure the safety and wellbeing, including protection from harm, for James. Thus, it would be a question of fact as to whether or not, by doing nothing to locate James after they knew he was missing, by failing to inquire as to where he was going and when he was expected back, in violation of their own policies, or by allowing him to leave without supervision, constituted a violation of MCL 400.706(6)(4) and the other statutory provisions cited herein.

C. *A Genuine Issue of Material Fact Exists as to Whether Defendant Stallworth's Breach of that Duty was a Proximate Cause of James' Death.*

In *Moning v Alfono*, *supra*, the Supreme Court described the interrelationship of duty and proximate cause:
"The questions of duty and proximate cause are interrelated because the question whether there is the requisite relationship, giving rise to a duty, and the question whether the cause is so significant and important to be regarded a proximate cause, both depend in part on foreseeability--**whether it is foreseeable that the actor's conduct may create a risk of harm to the victim, and whether the result of that conduct and intervening causes were foreseeable."**

Id. at 439 (emphasis added).

The Supreme Court has also delineated the quantum of evidence necessary to create a jury-submissible issue as to the existence of proximate cause:

> "On the other hand, if there is evidence which points to any 1 theory of causation, indicating a logical sequence of cause and effect, then there is a juridical basis for such a determination, notwithstanding the existence of other plausible theories with or without support in the evidence."

Skinner v Square D Co, 445 Mich 153, 164 (1994), quoting *Kaminski v Grand Trunk Western Railroad Co*, 347 Mich 417 477 (1956)

In that sense, then, the negligence of a party need only be "a" proximate cause of a litigant' injuries. *E.g.*, *Brisboy v Fibreboard Corp*, 540, 547 (1988). This principle is all the more significant when it is recognized that there may be more than one proximate cause of a litigant's injuries. *McMillian v Vliet*, 422 Mich 570, 578 (1985); *Bordner v McKernan*, 294 Mich 411, 414 (1940).

In this case, a genuine issue of material fact as to whether Stallworth's breach of one or more of the duties owed to James Stykos by Stallworth, as enumerated in the previous subsection, constituted a proximate cause of the death of Mr. Stykos. The most prominent breach of duty arose when Mr. Stykos was permitted to walk out of Stallworth on the evening of May 5, 2003. At that point in time, Stallworth, her agents and/or employees, knew, or should have known, that:

• He was a paranoid schizophrenic

• He abused numerous drugs

• He wandered

• He needed increased care

• His condition was worsening

• He exhibited bizarre behavior

• He made threats to staff

• His condition was grave, disabling and incapacitating

• He shouldn't go into the community unsupervised

• He has poor insight

There have been a number of cases with duty and proximate cause issues involving mentally ill and developmentally disabled persons in nursing homes arid foster care facilities. In the case of *Hammack v Lutheran Social Services of Michigan*, 211 Mich App 1 (1995), the circumstances involved a mildly retarded, seizure-prone developmentally disabled man placed into a licensed home who drowned while in a bathtub. The plaintiff alleged that had he been properly monitored his death could have been prevented. The defendant home entered into a contractual agreement akin to the agreement with this Defendant, which required them to deliver services pursuant to an Individual Plan of Service (IPS), just as in this case. A nursing plan indicated that the plaintiff should not be left alone while bathing due to his seizure potential. In this case, Plaintiff should not have been alone within the community.

In the *Hammack* case, the defendant claimed no duty was owed because there is no duty to aid or protect another relying upon *Williams v Cunningham Drug Stores, Inc*, 429 Mich. 495 (1988). However, the court found that a special relationship existed and the defendant's failure to monitor while bathing violated that duty was a question of fact for the jury.

The court also found that the breach of contract issue was also a question of fact for the jury. With regard to proximate cause, the court held:

> "With regard to the premises liability claim, as discussed earlier, defendants have admitted a special relationship existed giving rise to a duty. *That having been established, plaintiff presented sufficient evidence regarding the causal connection between the lack of monitoring and the death from which reasonable persons could draw a fair inference that defendants' negligence caused the injury*. Accordingly, this matter was appropriately sent to the jury. *Schedlbauer v Chris-Craft Corp.*, 381 Mich. 217, 233, 160 N.W.2d 889 (1968).

At 218.

In the case of *Hall v Cadillac Nursing Home*, 2000 WL 33538536 (Mich App) (see Exhibit 21 hereto), the court was presented with a case involving issues of duty and proximate cause. In *Hall*, the plaintiff pled both special relationship and breach of contract issues. The plaintiff alleged that a duty was owed by defendant to properly supervise and care for plaintiff decedent and to maintain his person in a reasonably safe condition, protecting him from foreseeable dangers. The claim against the nurse was that the standard of care required her to have knowledge of a resident's whereabouts at all times. The defendant claimed that the injuries and damages were proximately caused in whole or part by the decedent's own or third-parties' subsequent intervening negligence. The court noted that the decedent had history of alcohol abuse, disorientation, abusive behavior to staff and a tendency to wander off from the facility.

In *Hall*, the decedent left the facility. One employee saw him near an exit door but made no inquiry of him at 6:30 p.m. He was noticed missing at a bed check at 12:05 a.m. but the employee assumed he was away on a leave of absence for the weekend. The Detroit Police investigation revealed that Mr. Hall had gone to a store and was observed walking up and down the street, appearing lost and confused. He was observed drinking a beer with another man. He became combative and struck the other man on the head with a bottle and that man stabbed the decedent.

The court found a special relationship existed due to the fact that the defendant had assumed the care and supervision of decedent knowing that he suffered from dementia, paranoia, seizure disorder, alcoholism and at times exhibited aggressive behavior. The court distinguished the case of *Babula v Robertson*, 212 Mich App 45 (1995), which involved the sexual assault of a child by the babysitter's husband, which the court held was not foreseeable. What was different in the *Hall* case was the fact that the nursing home knew the decedent suffered from mental and physical illnesses and at times acted aggressively to others. The court searched for similar cases and found the case of *Bradley v Central Nangatuck Valley Help, Inc.*, 25 Conn L Rptr 178 (1999). (See Exhibit 22 hereto.)

The Bradley case involved a patient in a state licensed home suffering from traumatic brain injury, seizure disorder and alcoholism. He was struck by a car when he left the facility without authorization to buy alcohol. The defendant argued that they had no right to detain or confine him and therefore had no duty of care. The court noted that the defendant facility had knowledge of his condition and had a special relationship with him; thus, owing to the decedent such "reasonable care and attention for his safety as his mental and physical condition required."

After analyzing the *Bradley* case, the *Hall* court also found that a special relationship existed along with a duty of care owed by the defendants to the decedent. In analyzing the proximate cause issue, the Court analyzed the intervening cause issue and held:

> Plaintiff presented evidence that plaintiffs decedent was an identifiable victim foreseeably endangered. *Defendants had actual notice of plaintiff's decedent's mental illness, confusion, seizure disorder, alcoholic*

> *dementia and occasionally aggressive and violent conduct toward others. Defendants were aware that decedent often attempted to leave the premises without authorization in order to buy alcohol, and were aware that he should not drink when medicated Thus, there was evidence supporting that decedent was not killed simply as a victim of random and unforeseeable criminal conduct unrelated to decedent's condition and defendants' duty of care. Had decedent been shot by someone robbing the store, we would agree that while defendants' failure to exercise due care for decedent's safely would be a cause in fact of decedent's death in the sense that it would not have occurred had decedent not been permitted to leave the premises, it would not he a proximate cause of the death resulting form the unforeseeable criminal attack. However, there was evidence here that decedent was not a random victim of unpredictable violence, but that decedent's foreseeable behavior provoked the assault that caused his death. We therefore conclude that the circuit court erred in determining that reasonable minds could not differ regarding whether defendants' actions were a proximate cause of plaintiff's decedent's demise.*

At p 6.

According to Detroit Police investigation, James came upon his attacker while in a drunken condition. When approached in his drunken condition, James was perhaps lost. He then began to follow his assailant onto the high school playing field at or around midnight. James is Caucasian and the assailant was African American. (See Exhibit 24 hereto.)

To do such a thing at midnight reasonably could be related to a man who:
• Is a paranoid schizophrenic

• Is an abuser of numerous drugs

• Is a wanderer

• Needs increased care

• Is in a worsening condition

• Is exhibiting bizarre behavior

• Threatens people

• Is in a disabling and incapacitating condition

• Shouldn't go into the community unsupervised

• Has poor insight

Additionally, the case of *Carter v Stallworth AFC# 1 Corporation* (see Exhibit 23) is most relevant. It involved this very Defendant and issues of duty and proximate cause owed to an individual in need of adult foster care services. The decedent was a paranoid schizophrenic and a chronic alcoholic. Previously he had been residing in another foster care home but needed hospitalization and was committed to Riverview Hospital. He was discharged and placed by the same placement agency that placed your Plaintiff herein (Community Case Management Services) into the Stallworth AFC home. The decedent was driven to the Stallworth home but he refused to enter the facility and wandered away to his previous AFC home. Stallworth had no idea where he went. The next day Stallworth learned that the deceased returned to his previous AFC home.

That afternoon the deceased bought some alcohol and purchased some raw liver. He began to eat the raw liver in the kitchen of his previous AFC home and choked to death. The Court found a duty owed by Stallworth to the plaintiff. The court noted that the decedent "wandered away from Stallworth" and questions of fact remain over what steps were taken to supervise and monitor the decedent. The court also found questions of fact regarding the response taken by Stallworth to the situation presenting itself.

The court on the issue of proximate cause held:

> "Additionally, we believe there is a genuine issue of material fact as to whether any of these possible breaches of duty proximately caused the decedent's death. A factual question exists on whether but for the actions taken by these defendants, the decedent would not have died. Additionally, we believe a genuine issue of material fact exist on whether this injury was foreseeable and thus defendants should be held legally responsible. *Skinner v. Square D Co*, 445 Mich 153, 163;"

at p.4 (See Exhibit 23 hereto.)

The Defendants herein cite the case of *Jenks v Brown*, 219 Mich App 415 (1996), with which this Court is quite familiar. The *Jenks* case is distinguishable from the facts herein. In *Jenks*, the issue involved whether or not the defendants breached their duty under MCL 330.1946, the "duty to warn" statute, involving mental health professionals who learn from patients of a threat of physical violence against a reasonably identifiable third person and who has an apparent intent and ability to carry such a threat. In therapy the psychiatrist learned of an attempt to kidnap his child who was in her husband's custody and take the child underground. There was no threat to the plaintiff, thus the court held that there was no breach of the duty because the only threat of physical violence was to the child and not to the plaintiff. The facts of the *Jenks* case to those herein are remote. The duties imposed by statute and common law are completely different.

CONCLUSION

For the foregoing reasons, it is Plaintiffs position that he Defendant's Motion for Summary Disposition be denied in that questions of fact remain as to issues of duty and proximate cause that would require the trier of fact to determine.

Dated: June 30, 2005
GARRETT & STEVENSON, P.C.

By: <<signature>>

JON R. GARRETT (P25777)

Attorneys for Plaintiff

535 Griswold St., Suite 1650

Detroit, Michigan 48226

313/961-1885

End of Document